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DECOMPRESSION SICKNESS PRESENTING  
AS A VIRAL SYNDROME

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**ABSTRACT OF:**

Decompression sickness presenting as a viral syndrome

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Decompression sickness (DCS) is a well-known hazard of exposure to significant variations in ambient pressure. The diagnosis and management of DCS is frequently a source of confusion. Although the majority of cases are manifested by joint or limb pains (Type I DCS), patients may present with a wide array of symptoms, such as neurologic deficits, headache, fatigue, nausea, and respiratory difficulty. A thorough knowledge of the differential diagnosis and a strong index of suspicion are crucial to the proper management of DCS. Presented herein are two cases of altitude-related DCS which were confused initially with a viral syndrome. A discussion of the symptoms of DCS is included.

**Key terms:**      Recompression  
                         Altitude chamber  
                         Hyperbaric chamber  
                         Hyperbaric oxygen therapy



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## DECOMPRESSION SICKNESS PRESENTING AS A VIRAL SYNDROME

The United States Air Force (USAF) has extensive experience in the management of decompression sickness (DCS). Records of all DCS cases treated in USAF hyperbaric chambers are maintained at the USAF School of Aerospace Medicine (USAFSAM), Division of Hyperbaric Medicine, Brooks Air Force Base, Texas. Since 1985, two cases of altitude chamber DCS have been treated with hyperbaric oxygen therapy which were initially mistaken for a flu-like illness. Summaries of these cases are presented below, followed by a brief discussion of the signs and symptoms of DCS.

### Case 1

RC, a 19-year-old male, participated in an altitude chamber exposure to 35,000 feet. Several hours after descent he noted the onset of a frontal headache and nausea without emesis. He noted no other problems. He presented to a local medical center for treatment, and was given aspirin, and fluids, with partial resolution of symptoms. He was discharged from the emergency department with a presumptive diagnosis of viral syndrome, and was advised to report to his flight surgeon in the morning. The following morning the headache and nausea again increased in intensity, and was associated with abdominal discomfort. He had no fever, chills, or diarrhea. Examination revealed only mild abdominal tenderness without rebound or guarding. The remainder of the examination was normal. The possibility of decompression sickness was considered, and he was referred for recompression therapy. He was treated with a USAF treatment table 6. Within 30 minutes on 100% oxygen at 2.4 FSW all symptoms resolved. He remained asymptomatic throughout the treatment dive, and repeatedly requested food. Symptoms did not recur.

## Case 2

RC, an 18 year-old female altitude chamber technician, had an altitude chamber exposure to 35,000 feet. Immediately after the exposure she noted low back pain, followed shortly thereafter by lightheadedness, slow speech, headache, and fatigue. She also noted mid-abdominal discomfort and nausea without emesis. She later noted mild numbness and paresthesias in her left forearm. She attributed the symptoms to a viral syndrome, and took two aspirin and increased her fluid intake. The following morning all symptoms except the numbness and paresthesias had resolved, and she presented to her flight surgeon for treatment. Physical examination revealed decreased sensation in the left arm in the C6-C7 dermatome. No other abnormalities were noted. The diagnosis of Type II decompression sickness was considered, and she was referred for recompression therapy at a local hyperbaric chamber. Midway through a USAF table 6 treatment dive all symptoms resolved, and she remained asymptomatic.

## DISCUSSION

Decompression sickness is caused by the formation of bubbles of inert gas (usually nitrogen) within body tissues. Rapid lowering of the ambient pressure, such as during ascent in flying or in diving, leads to an increase in the tissue nitrogen load. When this nitrogen load reaches a threshold level (critical supersaturation level), bubbling occurs. Repetitive exposures before the body nitrogen level returns to equilibrium, such as with repetitive diving or with flying after diving, increases the risk of DCS substantially (3). Factors which may play a role in increasing susceptibility to DCS include increasing age (5), obesity (4), female sex (1), and exercise or other stress at depth (6).

The clinical manifestations of decompression sickness are variable, with many of the symptoms being protean. The varied nature of DCS has led Behnke to compare it with the spirochete as the

"great imitator" (2). The great number of signs and symptoms of DCS led Golding to classify it into Type I (joint/ limb pain only), and Type II (systemic symptoms) (7). This classification system is now widely used.

The many signs and symptoms of DCS can occur in any combination, which can make the diagnosis difficult. In 1964, Rivera published the experience of the U.S. Navy in treating 935 cases of DCS (8). In this series, localized pain was the most common symptom, occurring in 91.8% of cases. Other symptoms, in order of frequency, included numbness or paresthesias (21.2%), muscular weakness (20.6%), skin rash (14.9%), dizziness or vertigo (8.5%), and nausea or vomiting (7.9%). Other less common symptoms included headache (3.9%), fatigue (1.2%), and intestinal disturbance (0.4%).

From the above list of signs and symptoms, it is easy to see how, in the proper combination, DCS could be confused with a viral or flu-like syndrome. In Case 1, a physician diagnosed DCS as a viral syndrome when the patient presented with acute onset of headache and nausea. The diagnosis of DCS in this patient was confirmed when all symptoms rapidly resolved with recompression therapy. In Case 2, the patient interpreted the symptoms of back pain, headache, fatigue, lightheadedness, and nausea as a flu-like illness, which resulted in her delay in seeking treatment. These symptoms resolved spontaneously, but the numbness and paresthesias which developed in her arm resolved only after recompression therapy was instituted the following day.

A requirement for the treatment of any disease process is a full understanding of the clinical picture of the disease. This understanding can be especially difficult in DCS, with its broad spectrum of presenting signs and symptoms. In many cases, all or most of the manifestations are subjective, and the patient must be relied upon to present an accurate and truthful description of the problem. Divers and flyers must be educated to present for medical treatment when problems develop after the flying or diving activity. Health care providers must be able to identify individuals at risk for DCS and to recognize the bewildering array of possible presentations that are possible. When doubt exists, consultation with a diving or

hyperbaric physician should be obtained. In general, a test of pressure in a hyperbaric chamber is both diagnostic and therapeutic in these cases.

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